

## PREADMISSION SCREEN AND RESIDENT REVIEW (PASARR) LEVEL I SCREEN

This form is required under sections 42 USC 1936r(b)(3)(F) and 1396r(e)(7). Note: These sections also are referred to as 1919(b)(3)(F) and 1919(e)(7) of the Social Security Act.

**NOTE: Under these sections, nursing facilities MUST NOT admit any new resident who is suspected of having a serious mental illness or a developmental disability unless the State mental health authority / State developmental disability authority or designee has evaluated the person and determined if the person needs nursing facility placement and if the person needs specialized services, except as provided in Section B of this form.** If a nursing facility admits a resident without completion of the appropriate screen(s), then the facility is in violation of the statutory requirement, which may result in initiation of termination action against the facility.

If a Level II Screen is required, then information on this (Level I) form is matched with information from the person's Level II Screen to ensure that the facility, the Department's designee and the Department have complied with all applicable federal statutes and regulations. Information on this form will be used for no other purpose.

**42 CFR 483.128(a) requires that the resident or his / her legal representative receive a written notice (copy of this front page) if the resident is suspected of having a serious mental illness or a developmental disability, and therefore, will require a Level II Screen.** You may tell the resident or his / her legal representative that the Level II Screen will determine if the resident does have a serious mental illness or developmental disability, as defined in the federal regulations, and if so, if the resident needs nursing facility placement and if the resident needs specialized services.

Name - Resident	Birthdate (mm/dd/yyyy)	Social Security Number
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Address - Resident (Street, City, State, Zip Code) **For Preadmission Screens Only**

Name - Nursing Facility

Address - Nursing Facility (Street, City, State, Zip Code)

Name - Guardian (if applicable) or Health Care Agent (if the Durable Power of Attorney for Health Care document has been activated)

Address - Guardian or Health Care Agent (Street, City, State, Zip Code)

Telephone Number - Guardian or Health Care Agent

Home: \_\_\_\_\_ Work: \_\_\_\_\_

Check one of the boxes below **based on the responses to the questions in Section A of this form.**

☐ The resident is not suspected of having a serious mental illness or a developmental disability.

The resident is suspected of having (check the appropriate box below and forward a copy of this Level I Screen to the regional screening agency):

- ☐ A serious mental illness;  
☐ A developmental disability; or  
☐ Both a serious mental illness and a developmental disability.

**SIGNATURE** - Staff Member Completing This Screen **NOTE:** Sign after completing pages 1 - 4.

Title	Telephone Number
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Date Screen Completed (mm/dd/yyyy)	Date Referred to Screening Agency (mm/dd/yyyy)
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## INSTRUCTIONS

Federal law requires that all persons requesting admission to a nursing facility must be screened to determine the presence of a major mental illness and / or a developmental disability. **42 CFR 483.75(l)(5) requires the nursing facility to keep a copy of this form and other PASARR documents, if any, in the resident's clinical record.**

Complete this form by checking the boxes in Sections A, B and C and follow the instructions at the end of each section. Be sure to sign and date the form on the bottom of the front page when you are finished.

**PREADMISSION:** All persons seeking admission to a nursing facility must receive a Level I Screen prior to admission.

**READMISSION AND INTERFACILITY TRANSFERS:** Persons who are being readmitted to the same nursing facility after a hospital stay of any length may be readmitted without completion of another Level I or Level II Screen unless the person experiences a significant change of status. Residents who are transferred from one nursing facility to another, with or without an intervening hospital stay, are not subject to a new Level I or Level II Screen. However, **the transferring nursing facility is responsible for ensuring that any PASARR documents (Level I, as well as Level II Screen, if any) accompany the transferring resident.**

**SIGNIFICANT CHANGE IN STATUS:** For those persons presently residing in a nursing home, this form should be filled out only if there is a change of status in Section A. Note: All documentation in a person's record should reflect current functioning and current interpretations of statutes and regulations.

## SECTION A QUESTIONS REGARDING MENTAL ILLNESS

Yes No

### 1. Current Diagnosis

☐ ☐

Does the person have a major mental disorder under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised (DSM III-R) or DSM IV? Check the "Yes" box if the person's symptoms and behaviors could support an appropriate diagnosis of a major mental illness under DSM III-R or DSM IV. Check the "No" box if the person's mental illness symptoms / behaviors are directly caused by a medical condition (e.g., hypothyroidism can cause depressive symptoms; a stroke in the frontal lobe may cause decreased appetite and weight loss).

### 2. Medications

☐ ☐

Within the past six months, has this person received psychotropic medication(s) to treat symptoms or behaviors of a major mental disorder under the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, revised (DSM III-R) or DSM IV (see the above box for clarification)? If the person received psychotropic medication(s) to treat a medical condition, symptoms or behaviors that are due to a medical condition, or otherwise do not suggest the presence of a major mental illness, then provide a progress note in the person's record identifying the medication(s) and medical reason (e.g., symptoms or behaviors) for which the medication(s) is prescribed. For example, Elavil, which is an antidepressant, may be prescribed to alleviate pain; Remeron, which is an antidepressant, may be used to increase appetite that was diminished due to a stroke. Attach a copy of the progress note to this Level I Screen.

Check all applicable boxes below and check the name of the psychotropic medications the person has received within the past six months. The below list includes the trade names of commonly used psychotropic medications and is not meant to be comprehensive. Some medications are approved for multiple purposes (e.g., Paxil may be used to treat anxiety or depression; Tegretol may be used as an anticonvulsant or a mood stabilizer).

- |  |                                    |  |                                    |                                   |                                  |
|--|------------------------------------|--|------------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Antipsychotics - Typical:               | <input type="checkbox"/> Haldol    | <input type="checkbox"/> Loxitane          | <input type="checkbox"/> Mellaril  | <input type="checkbox"/> Moban    | <input type="checkbox"/> Navane  |
|  | <input type="checkbox"/> Prolixin  | <input type="checkbox"/> Seroquel          | <input type="checkbox"/> Thorazine | <input type="checkbox"/> Trilafon |                                  |
| <input type="checkbox"/> Antipsychotics - Atypical:              | <input type="checkbox"/> Clozaril  | <input type="checkbox"/> Risperdal         | <input type="checkbox"/> Zyprexa   |                                   |                                  |
| <input type="checkbox"/> Anti-anxiety (anxiolytics):             | <input type="checkbox"/> Ativan    | <input type="checkbox"/> Buspar            | <input type="checkbox"/> Valium    | <input type="checkbox"/> Xanax    |                                  |
| <input type="checkbox"/> Antidepressants:                        | <input type="checkbox"/> Celexa    | <input type="checkbox"/> Effexor           | <input type="checkbox"/> Paxil     | <input type="checkbox"/> Remeron  | <input type="checkbox"/> Serzone |
|  | <input type="checkbox"/> Trazadone | <input type="checkbox"/> Wellbutrin        | <input type="checkbox"/> Zoloft    |                                   |                                  |
| <input type="checkbox"/> Mood stabilizers:                       | <input type="checkbox"/> Depakote  | <input type="checkbox"/> Lithium Carbonate | <input type="checkbox"/> Lithobid  | <input type="checkbox"/> Tegretol |                                  |
| <input type="checkbox"/> Other - Specify medication(s) received: |                                    |  |                                    |                                   |                                  |

**SECTION A QUESTIONS REGARDING MENTAL ILLNESS (continued)**

Yes   No

**3. Symptomatology**

- ☐   ☐ Has the person displayed any of the following symptoms that may suggest the presence of a major mental illness? Check the "No" box if these symptoms are directly caused by a medical or neurological condition.
- a. Suicidal statements, gestures, or acts
  - b. Hallucinations, delusions, or other psychotic symptoms
  - c. Severe and extraordinary thought or mood disorders

**QUESTIONS REGARDING DEVELOPMENTAL DISABILITIES**

- ☐   ☐ 4. Is there a diagnosis or history of mental retardation?
- ☐   ☐ 5. Is there a diagnosis of cerebral palsy, epilepsy, autism, brain injury or any other condition, other than mental illness, that results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons and was manifested before the person was age 22?

**NOTE:** Wisconsin nursing home rules [HFS-132.51 (2) (d) 1.] require that no person who has a developmental disability may be admitted to a nursing facility unless the person requires skilled nursing facility (SNF) services.

*If you have answered "No" to all the above questions in Section A, the person does not require further PASARR evaluation. Sign this form and place in the person's chart. No further action needs to be taken. The nursing facility does not need to obtain county approval (i.e., a signed DDE-822 form) to be able to admit the person. If you have answered "Yes" to any of the questions, proceed to Section B.*

**SECTION B SHORT-TERM EXEMPTIONS**

The following situations, which are all for short-term admissions, are the only exemptions from Level II Screening.

Yes   No

**1. Hospital Discharge Exemption - 30 Day Maximum**

- ☐   ☐ Is this person entering the nursing facility from a hospital for the purpose of convalescing from a medical problem for 30 days or less?

**2. Pending Alternate Placement - 30 Day Maximum**

- ☐   ☐ Is this person entering the nursing facility for a short-term stay of 30 days or less while an appropriate placement is located? This person may be entering the nursing facility from any setting.

**3. Emergency Placement - 7 Day Maximum**

- ☐   ☐ Is this person entering the nursing facility because it appears probable that an individual will suffer irreparable physical or medical decline, injury or death as a result of developmental disabilities, infirmities of aging, chronic mental illness or other like incapacities if not immediately placed?

**4. Respite Care - 7 Days Per Stay Maximum; 30 Days Per Year Maximum**

- ☐   ☐ Is this person entering the nursing facility to provide a planned respite to in-home caregivers after which the person is expected to return to his / her home? Note: Medicaid payment for a nursing facility stay is not permissible for respite care, unless the person receives Medicaid Waiver funds (e.g., CIP) and the budget for the use of the waiver funds includes respite care.

**Additional Directions**

*If you have answered "Yes" to any of the items in Section B, the person may enter the nursing facility with county approval, as evidenced by receipt of a signed DDE-822 form from the county, for the specified period of time without a referral for a PASARR Level II Screen. Note: For emergency placements, a signed DDE-822 form is not required prior to admission, however, a request for the DDE-822 should be made on the first business day following admission.*

*If, during the short-term stay, it is established that the person will be staying for a longer period of time than permitted above, the person must be referred for a Level II Screen on or before the last day of the permitted time period. Medicaid payments are not to be made to a nursing facility after the last day of the permitted time period until the Level II Screen is completed if the facility fails to make a referral for a Level II Screen within the permitted time period.*

*If you have answered "No" to the questions in Section B, proceed to Section C.*

**SECTION C QUESTIONS PERTINENT FOR AN ABBREVIATED LEVEL II SCREEN (Please refer to DDES Memo Series 2004-18 for pertinent PASARR definitions)**

Yes      No

- ☐      ☐
1. **Severe Medical Condition**
- Check the "Yes" box only if the answers to both of the following questions is yes.
- a. Does the person have a severe medical condition, including but not limited to Chronic Obstructive Pulmonary Disease (COPD), Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis (ALS) or Congestive Heart Failure (CHF), or a terminal illness (a physician has indicated there is six months or less of life expectancy)?
- b. Does the person's medical condition substantially limit the person's ability to participate in activities? For example, a person may have COPD and be on continuous oxygen, but still be able to go shopping with family for several hours – this person would not receive an Abbreviated Level II Screen. On the other hand, a person may have COPD to such an extent that he / she becomes exhausted after being out of bed for a half hour – this person likely would receive an Abbreviated Level II Screen.
2. **Severe Cognitive Deficits**
- ☐      ☐
- Does the person have cognitive deficits due to dementia, Alzheimer's disease or similar degenerative process that substantially interferes with his / her independent functioning and results in a level of impairment that the person could not be expected to participate in or benefit from specialized services? For example, a person who can follow only one-step directions, scores low on the Mini-Mental Status Exam, cannot remember a list of three items after five minutes, etc. generally should qualify for an Abbreviated Level II Screen. In addition, there must be documentation that provides a reasonable basis for concluding that these deficits are not due to a reversible condition (e.g., delirium, depression, or drug interactions / side effects). Also, for persons who have a developmental disability or a long-standing history of a serious mental illness, it is essential to include information about prior functioning to demonstrate that there has been a decrease in functioning compared to prior levels.

***If you have answered "Yes" to any of the questions in this section, you are required to send to the PASARR contractor the Level I Screen along with documentation, such as tests, other evaluations, and pertinent progress notes to verify the medical or cognitive condition and the severity of impact the condition has on the person's independent functioning. The PASARR contractor will determine if the documentation supports the criteria for an Abbreviated Level II Screen. Follow the instructions in Section D.***

**SECTION D REFERRING A PERSON FOR A LEVEL II SCREEN**

***If you have answered "Yes" to any question in Section A and "No" to all of the exemptions listed in Sections B, follow these instructions:***

Contact the PASARR Contractor to notify them that the person is being considered for admission. Forward a copy of the Level I Screen to the PASARR Contractor (a copy must also be maintained by the nursing facility). The PASARR Contractor will perform a Level II Screen to determine if the person has a developmental disability and / or a serious mental illness as defined by the federal PASARR regulations, and if so, then whether or not the person needs nursing facility placement and if the person needs specialized services. The screening agency will notify the nursing facility, the county of responsibility and the resident or his / her legal representative, in writing of the determinations.

If you have answered "Yes" to any of the items in Section A, the nursing facility must obtain county approval, as evidenced by receipt of a signed DDE-822 form from the county, prior to admission.

Note: If a person has a developmental disability or a mental illness at the time of a proposed admission to a nursing facility, State statutes only permit a health care agent to admit a person to a nursing facility for up to three months of post-hospitalization recuperative care or for up to 30 days of respite care. Otherwise, guardianship and protective placement is necessary prior to admission, except in the event of an emergency. Similarly, if a person already has a guardian, the guardian is only permitted to consent to an admission to a nursing facility for up to three months of post-hospitalization recuperative care or for up to 30 days of respite care. Otherwise, a protective placement order is necessary prior to admission, except in the event of an emergency.